USAID | INDIA
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HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	1.13 billion (mid-2007)
Estimated Population Living with HIV/AIDS**	2.5 million [2 million-3.1 million] (end 2006)
Adult HIV Prevalence**	0.36% (end 2006)
HIV Prevalence in Most-At-Risk Populations***	IDUs: 6.9% (2006) MSM: 6.4% (2006) Sex Workers: 4.9% (2006)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy****	6-15% (2006)

*U.S. Census Bureau **UNAIDS 2007 ***UNGASS Country Progress Report 2008
****WHO/UNAIDS/UNICEF Towards Universal Access, April 2007

The first HIV/AIDS case in India was identified in Chennai, Tamil Nadu, in 1986. Twenty years later, in 2006, 2.5 million Indians were HIV positive, according to an estimate by UNAIDS. Estimated national prevalence, however, remains below 1 percent. This new estimate is significantly lower than previous estimates but is considered more accurate because it is based on a national household survey, the National Family Health Survey, 2005–2006 (NFHS-3), which included HIV testing of more than 100,000 people and was supported by expanded surveillance efforts.

According to UNGASS, India's epidemic is concentrated within high-risk groups, among whom prevalence is substantially higher than it is in the general population. Prevalence also varies dramatically by district, state, and region, with numerous isolated pockets of high prevalence. In Tamil Nadu and other southern states where a large number of people living with HIV/AIDS (PLWHA) reside, HIV prevalence was about five times higher than in northern states from 2000–2004, according to UNAIDS. However, even in states with a low prevalence, there are pockets of high prevalence. At the overall national level, trends among antenatal clinic (ANC) attendees, injecting drug users (IDUs), and sex workers appear to be on the decline, while trends among men having sex with men appear to be stable. Moreover, of India's 600 districts, 156 have a high HIV prevalence (more than 1 percent among ANC attendees) among the general population,and 39 have a high HIV prevalence (more than 5 percent) among high-risk groups.

The 2008 India UNGASS country progress report indicates that sexual intercourse is the primary mode of transmission in India, accounting for about 87 percent of new HIV infections. In the northeastern states, injecting drug use is the main mode of transmission, though sexual transmission is increasing. Prevalence rates among IDUs are on the rise in many states, with new regions (such as the south) also showing upward trends among this group. Among sex workers, prevalence trends show a decline in the south, where targeted program interventions have had a greater reach and achieved broader coverage in terms of raising awareness, testing, and condom use. In the northeast, however, the 2008 UNGASS report notes that prevalence among sex workers is increasing. India is a main destination for trafficked girls (especially from Bangladesh and Nepal) under age 16, and trafficked women and girls are particularly vulnerable to HIV infection, as they are often unable to negotiate condom use and subjected to violent sex. In 2005, the National AIDS Control Organization (NACO) reported that sex workers were HIV positive in urban areas, such as Mumbai (54 percent) and Pune (49 percent). With a national 2006 prevalence rate of 6.4 percent, the UNGASS report shows that trends among men who have sex with men (MSM) do not appear to show any decline.

As the epidemic shifts from the most vulnerable populations (IDUs, sex workers, and MSM) to "bridge" populations (clients of sex workers and partners of IDUs) in India, HIV is becoming more common among women and rural inhabitants, who accounted, respectively, for 39 and 67 percent of PLWHA in 2006. Historically, these groups have been more difficult to reach with public education campaigns, but awareness is on the rise. The NFHS-3 found that 61 percent of women ages 15 to 49 had heard of AIDS, compared with 84 percent of men. Smaller percentages (20 percent of women and 36 percent of men) had comprehensive correct knowledge of HIV/AIDS (measured by the ability to identify consistent condom use and fidelity as the two major ways of preventing sexual HIV transmission and mosquito bites and sharing food as the two most common misconceptions about HIV/AIDS transmission). Young women living in urban areas were more than twice as likely as those in rural areas to have comprehensive knowledge of HIV/AIDS. Only 40 percent of pregnant women knew that HIV/AIDS can be transmitted from mother to child and just 15 percent knew that taking certain drugs can reduce the likelihood of transmission.

Many Indians, including health care providers, consider AIDS a disease that affects only people with unorthodox lifestyles. This attitude reflects the stigma and discrimination directed toward Indians infected or affected by HIV/AIDS and contributes to the inadequate health care services they receive. Compounding the problem, negative attitudes from health care staff cause anxiety and fear among many PLWHA, who, as a result, hide their HIV status and thereby miss the opportunity to avail themselves of treatment. Gender inequality has also contributed to the epidemic, as women often lack the power to negotiate or assert their rights in regard to their sexual choices and, more broadly, their accesss to education, economic opportunity, and health care.

India had a high rate of estimated tuberculosis (TB) incidence of 168 cases per 100,000 population in 2006, according to the World Health Organization (WHO). The HIV-TB co-infection rate of adults testing HIV positive among incident TB cases is 1.2 percent. Co-infection complicates treatment and care for both diseases.

National Response

NACO was established in 1992 to formulate HIV policy and monitor prevention and control projects. That year, the Government of India also launched the first phase of its National AIDS Control Programme (NACP-I). NACP-I, which ended in 1999, had several elements, including HIV surveillance and related activities, screening of blood and blood products, and a public education campaign. With NACP-II, which lasted from 1999 to 2006, the focus shifted from raising awareness to interventions to change behavior. Currently in its third phase, NACP-III (2007– 2012) is designed to reverse the spread of HIV/AIDS by placing highest priority on prevention efforts while also seeking to integrate care, support, and treatment strategies.

Prime Minister Manmohan Singh's government has taken an aggressive stance toward combating HIV/AIDS since elected in 2004. Funding increased for HIV/AIDS activities from $58 million in 2003 to $204 milllion in 2007, and the National AIDS Council was established under the leadership of the Prime Minister, bringing together the heads of the different ministries. For the past three years, government hospitals in the high-prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur, Nagaland, and Delhi have distributed Indian-manufactured antiretroviral drugs (ARVs) free of charge and now ARVs are provided in many other states under a national program. The Indian Government has a target of providing free antiretroviral therapy (ART) to 300,000 PLWHA by 2011.

In mid-2005, the World Economic Forum released *Business & HIV/AIDS: A Healthier Partnership*, a report that found that many Indian companies did not provide adequate prevention programs for their employees. Since then, some local businesses have started to address the epidemic. In 2005, CoRE-BCSD India, a 52-company conglomerate dedicated to sustainable development, added "strengthening industry's response to HIV/AIDS" to its mission. In 2006, the Confederation of Indian Industry and the Global Business Coalition on HIV/AIDS, with the support of Prime Minister Singh, initiated a project to engage corporations that outsource their work to India. In 2006, the U.S. and Indian Governments launched the Indo-U.S. Corporate Fund for HIV/AIDS to increase private sector involvement. To date, the fund has received more than $1.3 million in pledges.

India is the recipient of eight grants for HIV/AIDS from the Global Fund to Fight AIDS, Tuberculosis and Malaria. These include a third-round HIV/TB grant to reduce TB-related morbidity among PLWHA while preventing further spread of HIV and TB in the rural populations of six high-burden HIV states. In addition, three sixth-round grants seek to expand access to ART and counseling and testing facilities, scale up care and support services for HIV-infected and -affected children, and promote access to care and treatment. The U.S. Government provides one-third of the Global Fund's total contributions.

Acceleration of ART programming may be anticipated in the next few years, as India has only recently begun to scale up its programs, and the country has high treatment needs – WHO estimates that just 6 to15 percent of those in need of ART currently receive it. ART among IDUs in the northeastern states is even lower at 1.4 percent, despite the fact that injecting drug use was the main factor in HIV transmission in this part of the country. According to UNAIDS, only 1.6 percent of pregnant women receive treatment to reduce mother-to-child HIV transmission. Within the framework of the NACP-III, the Government of India aims to provide, by 2010, ART to 62 percent of adults and children with advanced HIV infection and will provide treatment to reduce mother-to-child transmission of HIV in all pregnant women.

USAID Support

Through the U.S. Agency for International Development (USAID), India in fiscal year 2008 received $22 million for essential HIV/AIDS programs and services. USAID programs in India are implemented in partnership with the U.S. President's Emergency

Plan for AIDS Relief (Emergency Plan/PEPFAR). The Emergency Plan is the largest commitment ever by any nation for an international health initiative dedicated to a single disease. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years. The total funding for U.S. Government HIV/AIDS programs in India is $30 million.

Reauthorized on July 30, 2008, the U.S. is continuing its commitment to global AIDS in the amount of $39 billion for HIV/AIDS bilateral programs and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Working in partnership with host nations, the initiative will support antiretroviral treatment for at least 3 million people, prevention of 12 million new HIV infections, and care and support for 12 million people, including 5 million orphans and vulnerable children.

Until recently, USAID and PEPFAR activities in India emphasized HIV prevention in high-prevalence states and among at-risk groups; care and support for HIV-affected or -infected people; and engagement of the private sector in the fight against HIV/AIDS. Indian and U.S.-based companies, for example, are being encouraged to support HIV/AIDS programs for their workers and communities as part of an effort to develop a broader coalition of private partners to support national AIDS efforts. NFHS-3, conducted with assistance from the U.S. Government, was the first of the National Family Health Surveys to include HIV/AIDS prevalence estimates among the general population, and it is now accepted as the key data source for providing new national HIV prevalence estimates. USAID has also focused on AIDS-affected children, HIV surveillance, and voluntary testing and counseling.

USAID has supported these priorities through several major programs that provide financial and technical assistance to nongovernmental organizations (NGOs) and national and state governments. Among the longer-standing USAID programs are the AIDS Prevention and Control Project (APAC), launched in 1992, which works in Tamil Nadu and Pondicherry, and the Avert project in Maharashtra, launched in 1999. APAC has achieved significant success in Tamil Nadu; condom use among high-risk groups nearly doubled to 80 percent in 2006 from 44 percent in 1996, and sex with casual partners decreased from 48 to 34 percent during the same period.

HIV prevalence among pregnant women in the antenatal period declined from 1.6 percent in 1999 to 0.5 percent in 2005. The Government of India is scaling up nationally many of the models developed by APAC and Avert to reach high-risk groups and AIDS-affected populations. In 2007, USAID initiated Project Samastha, a comprehensive five-year program focused on HIV/AIDS prevention, care, support, and treatment in 12 high-prevalence districts in Kamataka and five districts in Andhra Pradesh. USAID is also supporting a project to increase private sector engagement and provide technical assistance to national and state governments.

More recently, the emphasis of the broader PEPFAR program. including USAID activities, is shifting under NACP-III. Increasingly, USAID is shifting support from direct implementation to technical support to both NACO and the State AIDS Control Societies (SACSs). Under NACP-III, USAID is initiating support for technical support units (TSUs) in Tamil Nadu, Puducherry, Kerala, Maharashtra, Goa, Uttar Pradesh, and Uttaranchal. The TSUs are taking leading roles in supporting the SACSs by providing technical guidance, training, supervision, and management of NGO programs, with the goal of transferring these responsibilities to the states within a few years.

Important Links and Contacts

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USAID HIV/AIDS Web site for India: http://www.usaid.gov/our_work/global_health/aids/Countries/ane/india.html

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids